

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-015182

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 151

STATE FILE NUMBER

FILED MAY 13 1963

VS 300  
Rev. 4/59

1 0147

2 0880

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Randolph</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton</b>		Length of stay in lb <b>6 Months</b>	c. CITY OR TOWN <b>Higbee</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital # 1</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>unk</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Moore</b> Last <b>Sanderson</b>		4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 27, 1890</b>
9. AGE (last birthday) <b>73</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lineman &amp; Construction work Bell Tel. Co</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ohio</b>	
11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Robert G. Sanderson</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Helen Akens</b>	
14. NAME OF HUSBAND OR WIFE <b>unk</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>	
16. SOCIAL SECURITY NO. <b>State Hospital # 1 Fulton, Mo</b>		17. INFORMANT <b>State Hospital # 1 Fulton, Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lungs-bronchopneumonia C abscesses</b> Chronic brain syndrome advanced arteriosclerosis DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour - Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>State Hospital #1</b>		20f. CITY, TOWN, OR LOCATION <b>Fulton, Mo</b>	
21. I attended the deceased from Sept. 28, 1962 to May 8, 1963 and last saw her alive on 7:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.		XXXXXXX	
22a. SIGNATURE (Degree or title) <b>Frank Sanderson</b>		22b. ADDRESS <b>Fulton, Mo</b>	
22c. DATE SIGNED <b>5/9/63</b>		22d. LOCATION (City, town, or county) (State) <b>Higbee Mo</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 11, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Higbee City Cemetery</b>	
24. FUNERAL DIRECTOR <b>Million Greer</b>		25. DATE RECD. BY LOCAL REG. <b>May 9 - 1963</b>	
26. REGISTRAR'S SIGNATURE <b>Maritta Lawrence</b>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

MAY 22 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*Marion E. Millian*

Licensed Embalmer No. 3957

P. O. Address Moderly, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.